

Data Elements on Health Profession Licensing Forms

		Kansas State Board of Healing Arts																Board of Nursing				Dental Board										Board of Examiners				Board of Emergen									
General Category	Description	Athletic Trainer	Chiropractic, Postgraduate	Insurance and License	Medical Records	Chiropractic Doctor	Naturopathic Doctor	Occupational Therapist & PT	Physical Therapist & Assistant Licensure/PTA	Physician Assistant	Podiatrist	Radiologic Technologist	Respiratory Therapist	Respiratory Therapist	RN LPN LMHT	ARNP/ RNA Advanced Practice	RN LPN ARNP	RN LPN	Dental & Hygiene	Dental & Hygiene	Dental Hygiene	Dental Hygiene	Anesthesia License	Anesthesia License	Licenses to Practice	Dentist	Hygienist	Optometrist				EMS Legal Recognition BLS & ALS Verification of EMS													
		App	Rnwl	App	App	Rnwl	Rnwl	App	App	App	PT Rnwl	PTA Rnwl	App & Addn	App	Rnwl	App	App	App	App	App	Endrs	Srvy	App	Srvy	Reins	Rnwl	App	App	App	Change Spn	App	App	App	Rnwl	Reins	Rnwl	Reins	App by Exam	Recip	Gluco ma App	Rnwl	App	Rnwl	Reins	
	Date of Application																																												
Provider Personal Information	Last name of provider																																												
	First name of provider																																												
	Middle name of provider																																												
	Generational suffix of provider																																												
	Preferred title (Dr., Mr., Mrs. Ms, etc.)																																												
	Maiden, previous or other name used																																												
	Date of birth of provider																																												
	Place of birth																																												
	Social security number																																												
	NPI Number																																												
	UPIN																																												
	OETracker number																																												
	Active in the military?																																												
	U.S. Citizen?																																												
	Other citizenship status: qualified alien, foreign national, etc.																																												
	Ethnic origin of provider																																												
	Provider's marital status																																												
	Indicates gender																																												
Provider Non-Practice Contact Information	Address (street, city, state, zip)																																												
	Previous Address(es)																																												
	Phone number																																												
	Cell Phone number																																												
	Email address																																												
	Fax number																																												
	Name of county (or abbrv.)																																												
	Address of record (preferred adrss																																												
Provider's Work (Practice/Office / Agency)	Name of office/practice/agency																																												
	Address (street, city, state, zip)																																												
	Name of county (or abbrv.)																																												
	Phone number																																												
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		App	Rnwl	App	App	Rnwl	Rnwl	App	App	App	PT Rnwl	PTA Rnwl	App & Addn	App	Rnwl	App	App	App	App	App	App	App	App	Change Spnsr	App	App	App	Rnwl	Reins	Rnwl	Reins	App by Exam	Recip	Gluco ma App	Rnwl	App	Rnwl	Reins	
	Email address																																						
	Type of Practice																																						
	Hours of Operation																																						
	Othr Prfsnals practicing at site																																						
Provider	Language(s) Spoken																																						
Provider DEA	DEA number assigned to provider																																						
Provider Education High School	Highest education completed:																																						
	High school name																																						
	High school address																																						
	High school Grad date or GED date																																						
Post-Secondary/ Professional Training	Name of the educational institution (post-secondary and/or professional)																																						
	Address of institution																																						
	Education Start Date																																						
	Education End /Graduation Date																																						
	Name of internship/residency hospital or department, if applicable																																						
	Type of the degree/certificate (MD, etc.)																																						
	Internship details - Dates/ # of hours, names of supervisor/director of																																						
	Post-grad or post-doctoral sprvsn details - Dates/ # of hrs, sprvsr name																																						
	Accreditation of school/program																																						
	Name of program director																																						
Type of Program - Rotating or Non-Rotating																																							
Other Education	Any additional training/ education (med military, pub hlth, business, etc.)																																						
	Name of school/institution																																						
	Address of school/institution																																						
	Type of additional/other training, degree/certificate (MD, DO, RN, etc.)																																						

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		App	Rnwl	App	App	Rnwl	Rnwl	App	App	App	PT Rnwl	PTA Rnwl	App & Addn	App	Rnwl	App	App	App	App Rn/Lpn	Endrs	Srvy	App	Srvy	Reins	Rnwl	App	App	App	Change Spnsrc	App	App	App	Rnwl	Reins	Rnwl	Reins	App by Exam	Recip	Glucoma App	Rnwl	App	Rnwl	Reins				
	Name of specialty																																														
	Area of emphasis (clinical psych, school psych, etc.)																																														
	Applicant name on degree/transcript																																														
	Information specific to professional exams and/or graduate hours for																																														
	If not BOC certified, provide date are scheduled to sit for exam																																														
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Practicum	Did you, as part of degree requirements, complete a practicum?																																														
	Agency name where practicum was																																														
	Agency/college address																																														
	Sponsoring college/university																																														
	Beg & End Dates of practicum																																														
	Hours worked per week																																														
	Total practicum hours completed																																														
	Onsite practicum supervisors names																																														
	Supervisor(s) Address(es)																																														
	# of hrs were in direct client contact																																														
	Describe responsibilities in practicum																																														
	Coordinator																																														
	Preceptor, preceptor number																																														
	Date completed																																														
Continuing Education	Number of continuing educations hours in a specified period? (e.g.,																																														
Provider Certification/ Specialty	Name of Specialty Board																																														
	Name of specialty																																														
	Name of subspecialty																																														
	Indicates type of specialty (prim, sec, Member of specialty association?																																														

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		App	Rn wl	App	App	Rn wl	Rn wl	App	App	App	PT Rn wl	PTA Rn wl	App & Add n	App	Rn wl	App	App	App	App Rn/ Lpn	End rs	Srv y	App	Srv y	Rei ns	Rn wl	App	App	App	Change Spn srg	App	App	App	Rn wl	Rei ns	Rn wl	Rei ns	App by Exa m	Rec ip	Gluco ma App	Rn wl	App	Rn wl	Rei ns
	Submitting application for endorsement?																																										
Provider Certification/ License	Name of credential (License, Certification, Registration) for this application (or renewal, etc.)																																										
	Status of credential (? Current, active, inactive, expired, renewal etc.)																																										
	Offer an option to NOT renew																																										
	Certification/License Number																																										
	Certification Level or License suffix																																										
	Obtained re-licensure hours																																										
	Initial License Date																																										
	Kansas License Date																																										
	Expiration date of certification																																										
	Name under which license is to be/was issued?																																										
	Seeking temporary permit?																																										
	Ever previously filed app for lic in KS?																																										
	Other Professional license/certificate or temporary permit (P=Previously,																																										
	a. State/territory																																										
	b. Issuing body																																										
	c. Under what name?																																										
	d. license number																																										
	e. type of license/certificate																																										
	f. effective date/year issued or date of applic.																																										
	g. Date of most recent renewal																																										
	h. current status																																										
	i. Expiration date																																										
	j. original state of licensure?																																										
	k. If not continuous, what was non-licensed period?																																										

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[illegible]

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[illegible]

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Insurance	Professional Liability Ins Info																																											
Liab. Action	Ever sued for malpractice?																																											
Provider Criminal / Disciplinary Action	Ever arrested?																																											
	Ever convicted of a misdemeanor?																																											
	Ever convicted of a felony? Or if a felony, was it a crime of violence?																																											
	Any criminal proceedings pending (fed or state)?																																											
	Ever court martialled or dishonorably discharged?																																											
	Any investigation and/or discip. action (past or pending) against any license, certification, or registration?																																											
	License, certif. or reg. ever denied, revoked, suspended or other disciplinary action taken?																																											
	Complaint ever filed with a prfssnl assoc or certifying/licensing body?																																											
	Ever had allegations of sexual abuse																																											
	Licence/certification ever																																											
	Has employment been terminated/ suspended for misfeasance,																																											
	Ever been found guilty of or liable for fraud or deceit in connection with																																											
Public Trust	Been rejected for membership in a professional organization, had membership revoked, been censured																																											
	Ever aided or abetted a person, not a licensed soc. wrkr, in representing him/her as a licensed social worker?																																											
	Ever been dropped, suspended, expelled, fined, place on probation,																																											

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		App	Rn wl	App	App	Rn wl	Rn wl	App	App	PT Rn wl	PTA Rn wl	App & Add n	App	Rn wl	App	App	App	App Rn/ Lpn	End rs	Srv y	App	Srv y	Rei ns	Rn wl	App	App	App	Change Spn sgn	App	App	App	Rn wl	Rei ns	Rn wl	Rei ns	App by Exa m	Rec ip	Gla uco ma App	Rn wl	App	Rn wl	Rei ns
	Been warned,censured, had admissions monitored or limited or																																									
	Ever denied staff membership with a health facility?																																									
	Been requested to resign withdraw or terminate your position with a partnership,prof assn, or practice																																									
	Have you been denied a DEA or ST. narcotics/controlled substances reg. certifi., had it revoked, suspended, restricted in any way, or warned by such agency?																																									
	Ever denied provider participation in any medicaid or medicare programs?																																									
	Have you terminated, sanctioned penalized or had to repay money to any medicaid or medicare program.																																									
MISC	Are you currently registered by BSRB as the unlicensed assistant of a licensed KS psychologist?																																									
	Do you provide EMS services to your community and/or business/industry?																																									
	If yes to above, with what type of service as your involved?																																									
	If provide services to community and/or busnss/industry, who operates it?:not affiliated, fire																																									
	Current EMS involvement is:full time, part time,volunteer																																									
	Indicate method of compensation (EMS): No pay,call time,per call,hourly rate,salary.																																									

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		App	Rn wl	App	App	Rn wl	Rn wl	App	App	App	PT Rn wl	PTA Rn wl	App & Add n	App	Rn wl	App	App	App	App Rn/Lpn	End rs	Srv y	App	Srv y	Rei ns	Rn wl	App	App	App	Change Spn srg	App	App	App	Rn wl	Rei ns	Rn wl	Rei ns	App by Exa m	Rec ip	Gla uco ma App	Rn wl	App	Rn wl	Rei ns			
COURSE INFORMATION	Sponsoring organization, organization number/name, course number, course level, category, date																																													
	Course taken with Education Incentive Grand Funding? Y/N																																													
	Ever identified yourself as a social worker in Kansas(excluding student work)?																																													
Emerg. System for Advance Reg. of	Willing to be included on registry of potential volunteers during an emergency? Check one or more																																													
Professional Organizations	Membership in Prof.organization?																																													
	Participation in Professional org. meetings?																																													
	Willing to serve on medical/dental malpractice screening panel?																																													
	ECFMG (Certificate #, Issue Date, Exp Date																																													

Data Elements on Health Profession Licensing Forms

		Behavioral Sciences Regulatory Board																Health Occupations Credentialing												Brd of Pharmac								
General Category	Description	Licensure for Practice of Psycho		LM LP	LB SW or LM SW	LS CS W	LP C	LC PC	LM FT	LC MF T	LC P	Alcohol and Other Drug Abuse Counselor Registration				LP, LC P, LC PC, LC	LM LP, LC P, LM SW	LS CS W, LM MF T	LM FT, LC MF T	LC P, LC PC, LC	Adult Care Home Administrator License				Speech-language pathology or audiology			Dietitian License			Nurse Aide or Home Health Aide		Me dic ati on Aid	Ph ar ma cis t	Ph ar ma cy Te	Ph ar ma cy Int		
		App	Rec ip	App	App	App	App	Rei ns	App	App	App	App	App	Rn wl	Rei ns	Rec ip	Rn wl	Rei ns	Rei ns	Rei ns	Rec ip	App	Rn wl	Rec ip	Te mp	Rei ns	App	Rn wl	Rei ns	App	Rn wl	Rei ns	App	Intr St. App	App	App	App	App
	Date of Application																																					
Provider Personal Information	Last name of provider																																					
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	Preferred title (Dr., Mr., Mrs. Ms, etc.)																																					
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	Social security number																																					
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Provider Non-Practice Contact Information	Address (street, city, state, zip)																																					
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		App	Rec ip									App	App	App	App						Rei ns	App	App	App	App	Rn wl	Rei ns	Rec ip	Rn wl	Rei ns	Rei ns					Rei ns	Rec ip	App
	Email address																																					
	Type of Practice																																					
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	Type of the degree/certificate (MD, DO, etc.)																																					
	Internship details - Dates/ # of hours, names of supervisor/director of																																					
	Post-grad or post-doctoral sprvsn details - Dates/ # of hrs, sprvsr name																																					
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		App	Rec ip	App	App	App	App	Rei ns	App	App	App	App	Rn wl	Rei ns	Rec ip	Rn wl	Rei ns	Rei ns	Rei ns	Rec ip	App	Rn wl	Rec ip	Te mp	Rei ns	App	Rn wl	Rei ns	App	Rn wl	Rei ns	App	Intr St. App	App	App	App	App
	Name of specialty																																				
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	Information specific to professional exams and/or graduate hours for																																				
	If not BOC certified, provide date are scheduled to sit for exam																																				
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Practicum	Did you, as part of degree requirements, complete a practicum?																																				
	Agency name where practicum was																																				
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		App	Rec ip	App	App	App	App	Rei ns	App	App	App	App	App	Rn wl	Rei ns	Rec ip	Rn wl	Rei ns	Rei ns	Rei ns	Rec ip	App	Rn wl	Rec ip	Te mp	Rei ns	App	Rn wl	Rei ns	App	Rn wl	Rei ns	App	Intr St. App	App	App	App
	Submitting application for endorsement?																																				
Provider Certification/ License	Name of credential (License, Certification, Registration) for this application (or renewal, etc.)																																				
	Status of credential (? Current, active, inactive, expired, renewal etc.)																																				
	Offer an option to NOT renew																																				
	Certification/License Number																																				
	Certification Level or License suffix																																				
	Obtained re-licensure hours																																				
	Initial License Date																																				
	Kansas License Date																																				
	Expiration date of certification																																				
	Name under which license is to be/was issued?																																				
	Seeking temporary permit?																																				
	Ever previously filed app for lic in KS?																																				
	Other Professional license/certificate or temporary permit (P=Previously,																																				
	a. State/territory																																				
	b. Issuing body																																				
	c. Under what name?																																				
	d. license number																																				
	e. type of license/certificate																																				
	f. effective date/year issued or date of applic.																																				
	g. Date of most recent renewal																																				
	h. current status																																				
	i. Expiration date																																				
j. original state of licensure?																																					
k. If not continuous, what was non-licensed period?																																					

Data Elements on Health Profession Licensing Forms

		Behavioral Sciences Regulatory Board															Health Occupations Credentialing										Brd of Pharmac										
General Category	Description	Licensure for Practice of Psycho	LM LP	LB SW or LM SW	LS CS W	LP C	LP C LC PC	LM FT	LC MF T	LC P	Alcohol and Other Drug Abuse Counselor Registration	LP, LC P, LC PC,	LM LP, LC P,	LS CS W, LM SW	LM FT, LC MF T	LC P, LC PC,	Adult Care Home Administrator License	Speech-language pathology or audiology	Dietitian License	Nurse Aide or Home Health Aide	Me dic ati on Aid	Ph ar ma cis t	Ph ar ma cy Te	Ph ar ma cy Int													
		App	Rec ip	App	App	App	App	Rei ns	App	App	App	App	Rn wl	Rei ns	Rec ip	Rn wl	Rei ns	Rei ns	Rei ns	Rec ip	App	Rn wl	Rec ip	Te mp	Rei ns	App	Rn wl	Rei ns	App	Rn wl	Rei ns	App	Intr St. App	App	App	App	App
	I: other details																																				
	Providing volunteer or charitable health services?																																				
	Why was license allowed to expire?																																				
	Since license expired, have you _____ in Kansas?																																				
Provider Hosp. Privilege	Name of Hospital affiliation																																				
Provider Work History/Status	Employer name																																				
	Employer's address																																				
	Start Date																																				
	Ending Date																																				
	Position Title																																				
	Reason for Termination																																				
	Contact name																																				
	Contact Phone Number																																				
Other work history details																																					
Current /Recent Employment Status	Current Employment Status (working in prfsn, retired, not working, working in another state?)																																				
	Currently practicing in advanced role?																																				
Simplify by combining with above section?	Describe practice setting and professional responsibilities.																																				
	Were any hours worked in Kansas?																																				
	Hrs/wk in direct patient care in KS																																				
	Of the above - hours in Administration/ research/teaching																																				
	Working in nursing or mental health technician services in Kansas?																																				
	Specific information about current/recent employment																																				
	a: name of agency(ies)																																				
	b: name of associated physician																																				

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		App	Rec ip	App	App	App	App	Rei ns	App	App	App		App	Rn wl	Rei ns	Rec ip	Rn wl	Rei ns	Rei ns	Rec ip	App	Rn wl	Rec ip	Te mp	Rei ns	App	Rn wl	Rei ns	App	Rn wl	Rei ns	App	Intr St. App	App	App	App
	c: address of site(s)																																			
	d: county																																			
	e: phone number of site(s)																																			
	f: type of work setting																																			
	g: hours/week																																			
	h: % of hours																																			
	i: average # of patients seen per																																			
	j: weeks/year																																			
	k: BSRB License required?																																			
	l: working w/o supervision?																																			
	m: in a clinical supervisory training plan?																																			
	n: conducting psychotherapy																																			
	o: working under supervision?																																			
	p: supervisor's name/license type & "																																			
	q: other work details																																			
	Length of employment																																			
	Been continuously employeeed?																																			
Supervisory Role	Do you supervise: <u>P A</u> , <u>Athletic Trainer</u> , <u>Rad. Techn.</u> , <u>Phys. Ther</u>																																			
Provider Sponsorship	Sponsoring Professional <u>Name</u> , <u>Address</u> , <u>Phone</u> , <u>License #</u> ,																																			
Provider Medical Condition	Description of ability to safely practice																																			
	Used alcohol/drugs/ etc which may cause addiction/dependence, to																																			
	Used controlled substances w/o valid prescription?																																			
	Ever engaged in your practice while any phys. /ment. disability, loss of motor skill or use of drugs or alcohol,																																			
	Any physical/mental problems or disabilities which could affect ability to competently practice your profession?																																			

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		App	Rec ip	App	App	App	App	Rei ns	App	App	App	App	Rn wl	Rei ns	Rec ip	Rn wl	Rei ns	Rei ns	Rei ns	Rec ip	App	Rn wl	Rec ip	Te mp	Rei ns	App	Rn wl	Rei ns	App	Rn wl	Rei ns	App	Intr St. App	App	App	App	App
Insurance	Professional Liability Ins Info																																				
Liab. Action	Ever sued for malpractice?																																				
Provider Criminal / Disciplinary Action	Ever arrested?																																				
	Ever convicted of a misdemeanor?																																				
	Ever convicted of a felony? Or																																				
	Any criminal proceedings pending (fed or state)?																																				
	Ever court martialled or dishonorably discharged?																																				
	Any investigation and/or discip. action (past or pending) against any license,certification,or registration?																																				
	License, certif. or reg. ever denied, revoked, suspended or other disciplinary action taken?																																				
	Complaint ever filed with a prfsnal assoc or certifying/licensing body?																																				
	Ever had allegations of sexual abuse																																				
	Licence/certification ever																																				
Public Trust	Has employment been terminated/ suspended for misfeasance,																																				
	Ever been found guilty of or liable for fraud or deceit in connection with																																				
	Been rejected for membership in a professional organization, had membership revoked, been censured																																				
	Ever aided or abetted a person, not a licensed soc. wrkr, in representing him/her as a licensed social worker?																																				
	Ever been dropped, suspended, expelled, fined, place on probation,																																				

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MISC	Been warned,censured, had admissions monitored or limited or																																			
	Ever denied staff membership with a health facility?																																			
	Been requested to resign withdraw or terminate your position with a partnership,prof assn, or practice																																			
	Have you been denied a DEA or ST. narcotics/controlled substances reg. certifi., had it revoked, suspended, restricted in any way, or warned by such agency?																																			
	Ever denied provider participation in any medicaid or medicare programs?																																			
	Have you terminated, sanctioned penalized or had to repay money to any medicaid or medicare program.																																			
	Are you currently registered by BSRB as the unlicensed assistant of a licensed KS psychologist?																																			
	Do you provide EMS services to your community and/or business/industry?																																			
	If yes to above, with what type of service as your involved?																																			
	If provide services to community and/or busnss/industry, who operates it?:not affiliated, fire																																			
	Current EMS involvement is:full time, part time,volunteer																																			
	Indicate method of compensation (EMS): No pay,call time,per call,hourly rate,salary.																																			

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COURSE INFORMATION	Sponsoring organization, organization number/name, course number, course level, category, date																																				
	Course taken with Education Incentive Grand Funding? Y/N																																				
	Ever identified yourself as a social worker in Kansas(excluding student work)?																																				
Emerg. System for Advance Reg. of	Willing to be included on registry of potential volunteers during an emergency? Check one or more																																				
Professional Organizations	Membership in Prof.organization?																																				
	Participation in Professional org. meetings?																																				
	Willing to serve on medical/dental malpractice screening panel?																																				
	ECFMG (Certificate #, Issue Date, Exp Date																																				